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Inventory

A QUARTERLY JOURNAL ON ALCOHOL AND ALCOHOLISM

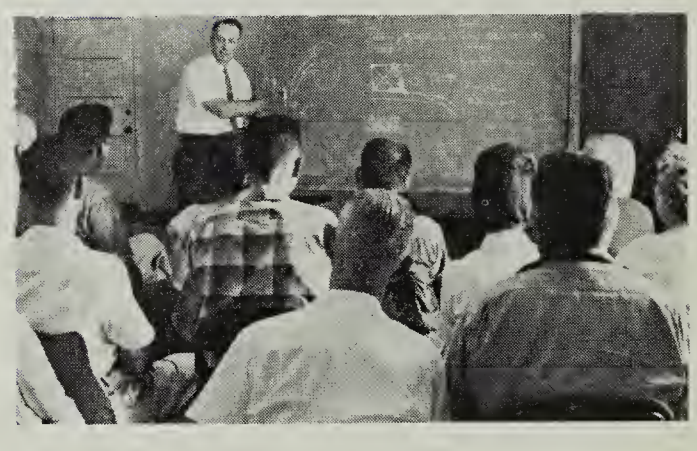
PUBLISHED BY THE N. C. DEPARTMENT OF MENTAL HEALTH

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.



A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Admission is entirely on a voluntary basis and a person cannot be accepted on court order or legal commitment. The Center cannot accept persons who have any court hearing or legal action pending which would interfere with or curtail their treatment program.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770 or 985-4420). All appointments are confirmed by mail. They should be made through a physician or other professional person in the prospective patient's community.

3. Patients are expected to be sober on admission, and the Center will not admit a person if intoxication impairs his functioning. The Center does not have nursing or hospital facilities to treat acute intoxication.

4. A written report of a recent physical examination by a licensed physician must be presented upon admission. The patient's physical and mental condition must be good enough to enable him to participate in the treatment program, walk up and down stairs, etc. The Center does not have hospital beds or nursing staff for the treatment of serious physical or mental disorders.

5. A fee of $7.00 per day is charged for the four weeks of treatment. This may be paid by cash or check at the time of admission, or by a note signed by the patient at the time of admission — promising to pay the full sum at some time after discharge.

If a person is indigent he may obtain a letter stating this fact from his local county welfare agency, and upon presentation of this letter at the time of admission the request for payment will be waived.

The Center does not refuse to admit any person because of lack of money, but feels that patients having treatment should take responsibility for the cost of the services if they are able to pay at the time of admission or later.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

Patients are admitted to the Center five days a week, Monday through Friday, between 9:00 a.m. and 12:00 noon and 1:00 p.m. and 5:00 p.m. by appointments as described above.

N. C. DEPARTMENT OF MENTAL HEALTH

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"The very fact that I knew I had lost my family and yet still wished to remain sober was proof in itself that my thinking was clearing."

TURNING POINTS

BY AN ANONYMOUS ALCOHOLIC

CERTAINLY a more singular feeling could not exist. This, I knew. It was a magnificent feeling. It spread through my body as a poignant perfume pervades a small room. It was one of those delectable moments, when I felt completely aware of my love for my three children, the meaning of true and sincere love.

As I watched them gleefully "spill out" the front doorway, I was happy. Musing over this happiness, I realized that life truly is stranger than fiction. During this relaxed, yet discernible, moment, I allowed my thoughts to digress to the most unhappy days I had known. My mind wandered back some four odd years.

At that time, four years ago, I imagined the beginning to be the end. Even the weather ominously adapted itself to the occasion on that particular day when I was led from the Mecklenburg County Jail through a cold and drizzly rain and locked in the rear of the gray prison "wagon" that would take me to the chain gang at Mount Pleasant. The judge had said, "one year"; and when you are thirty-six and have never been in front of a judge before, you first react with a depressive numbness that ever so gradually "tingles" into an even more depressed reality. The latter did not happen until I had reached the camp. It was there also that I requested an appeal. It was there that a shockingly simple answer to a logically (I thought) unanswerable question sparked a beginning rather than ending to a heretofore self-inflicted tragically useless existence.

If I may be permitted to regress further, prior to my return to Charlotte, N. C. and my subsequent arrest, psychiatrists and psycholo-

gists in Washington, D. C. and Veterans Hospital, Salisbury, N. C. agreed unanimously on one thing—that I was an alcoholic. Being consistent with my past nature, I accepted their diagnosis as halfheartedly as I accepted God and everything else of really true value. After all, I thought, I was a man of the world. I had joined the United States Marine Corps at age fourteen in April of 1942. I had fought at Tarawa, Saipan, Tinnian and Okinawa. I possessed the Purple Heart, Naval Commendation, a couple of Presidential Unit Citations, along with a few other ribbons. Upon discharge in April of 1946, I dynamited for an oil company out of Dallas, Texas, (seismographic work) until it dawned on me that I needed a formal education. I began where I left off, the eighth grade of grammar school, and managed to work my way through two years of college. It was somewhere during these years that I acquired the attitude that I could do no wrong.

From college, I followed a rootless and wandering life that led through some twenty or more different jobs. At the risk of sounding "corny" or "square" to some of todays very liberal "thinkers," my blind race toward degradation came on the heels of a rather Godless, booze-soaked decade that ranged from my twenty-fifth to thirty-fifth birthday. Toward the end, I was dragging my wife and children from city to city and job to job searching for the "big kill" which, on a few occasions, nearly turned into a small suicide.

A relative closeness of comedy and tragedy pervaded my life. There were times when I contemplated taking my own life, but by the time I had plied myself with alcoholic fortification in order to boost my nerve, I would be so far gone that I would instead announce to myself and the world at large, "To hell with it—live and let live." This had to be the grace of God, yet no one could mention Him without argument from me. My favorite "stopper" was, "If there is a **just** God, why does he take the lives of children?" I had, however, never "bought" the reply that God takes the lives of children to punish others, and knew I never would.

I had time to reflect on this and other things while at the prison camp. Mostly, I thought of my wife and children whom I knew I had now lost forever. At other times I would merely sit and think of nothing in particular. It was during one of these times that an amazingly simple answer to my prize "catch" question on religion came to me. I am still very much at a loss to understand why this particular "answer" should come to me "out of the blue" at this time. True, I had just about run out of time and sanity; but, I was more angry than repentant, more depressed than regretful. Yet, there it was—the answer—in the form of a question: "Would I believe God **just** had he taken me as a child?"

This answer I could understand. All that remained was to reflect on the dozens and dozens of people, most being the ones dearest to me, that I had brought grief and sorrow to, and simply visualize all the hurt and pain that never would have been had I been taken as a child.

Then came the real "shocker." That very same day I received a letter from my wife. My oldest son had had the first of two heart operations at Johns Hopkins Hospital in Baltimore. He was doing fine. The operation was a complete success. I also received word that

my other two children had to be placed in foster homes. This was the end, I knew, yet my demeanor remained unchanged. I knew my past, as is everyone's, is not without soil; yet, unlike most, it is splattered with unforgivable and self-inflicted splotches that would rival a degenerate heathen. I had been consistent in but two areas—drinking and running. It seemed the devil had begun to collect my dues. And yet, this strangeness of feeling flooded my entire being. I could not comprehend my own feelings since they felt so unlike my nature. It was as though someone had reached into my head and turned my brain inside out. Where I would normally have whined with self-pity and yearned for enough whisky to blot out reality, I did two things that night so contrary to my previous character that even today I haven't an explanation for my actions.

The Turning Points

Once a week, two or three men from Alcoholics Anonymous would meet with the inmates in the mess hall. This was the night, as if a planned and sobering parlay had been laid for me that day. I attended the meeting and pleasantly discovered it wasn't the fearful nor highly religious meeting I had anticipated. Instead, I found it to be a gathering of people like myself. I realized the severity of this comparison; yet, walking into the A.A. for the first time is not unlike strolling into your friendly neighborhood bar the hundredth time. I do not believe this kind of spontaneous fellowship can be found in any other organization. And as my former sponsor once pointed out to me, although A.A. is not a religious organization, it can most definitely become the doorway to religion.

The second thing I did that night was pray—harder than I ever had before—and not for myself, but for my family. I am certain God appreciated the change.

As my new trial neared, my new found convictions grew stronger. The very fact that I knew I had lost my family (which by the way is all I had left to lose) and yet still wished to remain sober was proof in itself that my thinking was clearing at last. Armed with this **sincere desire** for sobriety, reinforced with all the courage pre-bottle me could muster, I presented a different person in the courtroom this second time.

When the opportunity came for me to speak, it was a solemn and clear voice that filled the courtroom. I felt like a spectator to my own voice. Gone were the cobwebby thinking and quavery tones. Forgotten were the "do's and don'ts" offered by the "jailhouse lawyers." I now knew what manner of man this judge was, and is, and he is much too wise to be "conned" and, although a compassionate person, he would never let mere sympathy cloud his judgment.

I was completely clear of the courtroom before realizing the judge had set me free. Now came the somber task of returning to the apartment and packing. My wife greeted me very cordially and allowed me to see our son. Then we sat and talked. It was the first important sober conversation we had ever had. From this unusual sedate interchange blossomed the idea that with a little help and a lot of sobriety our marriage and family could be rescued.

I never packed my clothes. Instead, we embarked upon a new life with a swift vigor that would rival

(Continued on page 12)

BY LILLIAN PIKE
ALCOHOLISM PUBLICATIONS EDITOR
NORTH CAROLINA
DEPARTMENT OF MENTAL HEALTH

THE DOROTHEA DIX HOSPITAL

Alcoholism & Drug Addiction Unit

DOROTHEA Dix Hospital is owned by the State of North Carolina and operated under the authority of the N. C. Department of Mental Health as prescribed by law. In accordance with the law, it accepts for treatment mentally ill, alcohol and drug addicted patients from the South Central region of the State, as defined by the department.

All male addiction patients, alcoholics and drug addicts, are housed and treated together on the Alcoholism and Drug Addiction Unit. Female addiction patients participate in the rehabilitative aspects of the treatment program but are housed on the geographic units throughout the hospital. The unit has 60 beds for male patients, and in addition treats from 15 to 20 female patients. The average patient census is about 60 patients, and the average number of admissions per month is 120 patients.

The regular staff, or the staff assigned to the unit by the hospital, includes two physicians who are general practitioners —one serves as the part-time unit director and the other as the unit staff physician. There is a full-time nurse, social worker and medical records secretary; three full-time charge aides and six psychiatric aides. Two medical residents and two psychiatric residents help out part-time. In addition to the regular staff, staff from other areas of the hospital who participate in the treatment program include a psychiatrist, consulting psychologist, industrial therapist, recreation therapist, vocational rehabilitation counselor, chaplain and two senior staff nurses.

This article portrays the treatment program of the Alchoholism and Drug Addiction Unit as it is presently being carried out within the limitations of staff and funds, not as the staff and hospital would like for it to be. Acknowledgement is made, with appreciation, to the staff for their assistance in providing the material for this article and to the patients who posed for the pictures.

The Team Approach

The staff utilizes a "team approach" in treating patients. This simply means that they work together for the benefit of the patient in carrying out the treatment program. All the staff knows what the goals of treatment and the approved ways of attaining them are, and each staff member in performing his own role is carrying out the treatment program. In the team approach, the specialties of the staff members are emphasized less than continuity of treatment. Since all staff members are working toward the same goals and are involved in the total treatment program, each staff member's role or specialty is necessary to achieving the goal. The need to vie for authority is thereby obviated, releasing the special skills and energies of the individual staff members for application in the treatment program.

The team consists of the unit director, staff physician, nurse, social worker, charge aides, psychiatric aides and any of the participating staff from other areas of the hospital who are available, such as the industrial therapist, recreation therapist, vocational rehabilitation counselor, psychiatrist or psychologist.

The progress of the patients is evaluated at team meetings and decisions involving individual patients are made with the benefit of information and opinions and knowledge from all the staff. Problems encountered by the staff in their own specialty areas are also submitted for airing at team meetings. Another function of the team meeting is the sharing of knowledge or information which may be useful in treating the patients. For example, the social worker or the vocational counselor may lack information for their special evaluations of patients which may be supplied by some other staff member. An aide may need suggestions for coping with certain types of behavior problems. The team meeting, then, is a vehicle for solving special problems and sharing information.

The aides are the mainstay of continuity of treatment since they, working in three shifts, are with the patients twenty-four hours a day. They usually make the initial contact with the patients while admitting them at all hours of the day and night. They take care of and are with the patient constantly during his painful withdrawal period. The aides are involved, too, in the rehabilitative treatment that follows physical restoration of

the patient. They sit in on group sessions, follow through on staff plans for the patients, see that the patients are in the right place at the right time, and are close to the patients in many other ways. This gives them an advantage in observing the patients and in obtaining information of importance to treatment.

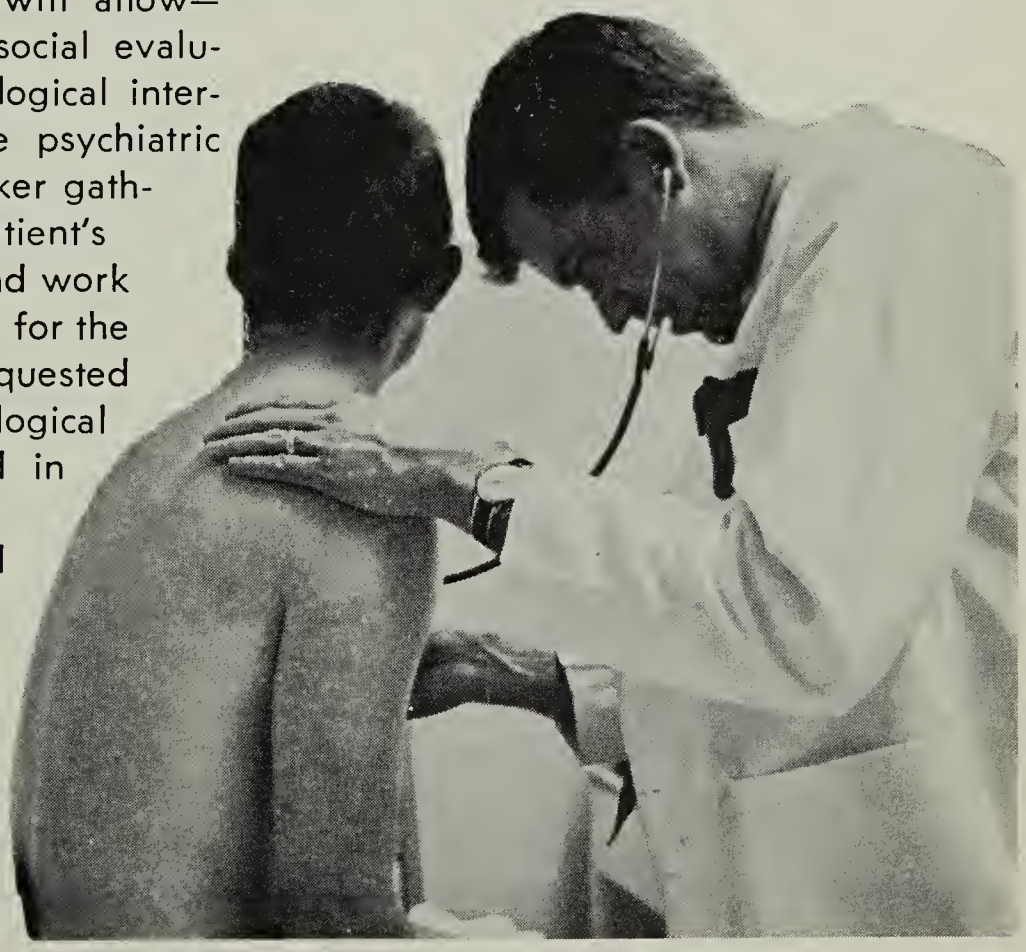
One aspect of treatment which pertains to staff attitudes bears mentioning. In order to be effective in treating addiction patients, the helping person, whatever his training or profession, must manifest a genuine conviction that he is dealing with a sick person worthy of help—not a moral degenerate. More than that, he must be able to accept the patient as an individual person apart from his addiction—not a bum. Any other attitude by mutual consent is simply not tolerated by the team.

Evaluating the Patient

In addition to the need for medical evaluation which — by virtue of the patient's condition when he arrives—is usually of an emergency nature, the patients—when they are able and to the extent that staff limitations will allow—undergo psychological and social evaluation interviews. The psychological interviews are conducted by the psychiatric residents, and the social worker gathers information on the patient's cultural background, social and work adjustments and family status for the social history. If especially requested by the physician, the psychological interview will be conducted in depth and a detailed social history will be compiled and the data confirmed through contacts with family members and community social agencies. The social worker is also concerned with working with the patient's family and establishing liason with community agencies for appropriate follow up and continued treatment of the patient after he leaves the hospital. The extent to which the social worker can enter into these areas is governed by the acuteness of the need and the time available.

Length of Stay

The Alcoholism and Drug Addiction Unit offers a 28-day treatment program which is divided into two phases—medical treatment and rehabilitative treatment. Under certain circumstances patients may be allowed to stay longer. For example, the patient who has no funds, no family and no place to live, even though he may be physically ready for discharge, may be allowed to remain in the hospital while arrangements are being made on the outside to meet his social and economic needs. Or a patient in the judgment of the staff may not be ready to withstand the family pressures with which he would be faced on discharge. Then there is the patient who is just not ready for discharge—physically, socially or psychologically.



Medical Treatment

Medical treatment begins as soon as the patient is admitted. It consists of a thorough physical examination which includes these routine tests: CBC (complete blood count), urinalysis, Wassermann and chest X-ray. Depending upon the condition of the patient, appropriate treatment is begun promptly for the purpose of: detoxifying the patient, easing his withdrawal symptoms, preventing seizures (convulsions) and delirium tremens, and treating other complications such as liver, muscle, or peripheral nerve disease or acute infections such as pneumonia.

In treating the patient medically, the physician makes use of drug therapy—including tranquilizers and antibiotics—intravenous fluids, diet and vitamin supplements as needed in individual cases. One measure of the effectiveness of the treatment regimen is the fact that fewer patients in the past year have developed convulsions or delirium tremens—after being treated. Some patients have these conditions when they arrive. If, in the opinion of the unit physician, a patient

is critically ill and in need of more intensive medical care than is afforded by the regular treatment regimen, he is transferred to the Medical-Surgical Unit of the hospital.

The patient usually remains on the closed medical area of the unit for seven days or until his physical condition permits his release to the open continued treatment area. Release to the continued treatment area is not to be equated with discharge from the hospital, although some patients leave at this time. However, if the patient leaves without special permission, his hospital record reads "discharged against medical advice."

Rehabilitative Treatment

Rehabilitative treatment begins after the patient's physical condition has improved sufficiently that he is released to the continued treatment area. Essentially the rehabilitative treatment program is designed to make it possible for patients to have a series of successful living experiences in important life areas—work, learning, profitable leisure that they may not have had in some time. Admittedly, these experiences occur in the sheltered atmosphere of the hospital and are thus unlike life on the outside. Nevertheless, under staff guidance they may serve, in time, to illustrate to the patients—if not convince them—that "successful living is possible without alcohol (or drugs)." In a sense, of course, what the patient gets out of rehabilitative treatment is up to him. The staff can arrange the therapeutic situation and encourage the patient's physical presence but cannot control what he chooses to take in or assimilate. However, the patient should not be blamed if he fails to get well or benefit from treatment, even though he did not participate fully in the program. Our scientific knowledge is not yet complete enough to ensure that the staff will reach all its patients, even if they cooperate to the fullest. Rehabilitative treatment makes use of the following therapies:

1) Group therapy

Patients are required to attend a group therapy session daily, except Saturday and Sunday. Hopefully, these sessions are educational as well as therapeutic. They are conducted by members of the

unit staff and staff from other areas of the hospital. In all sessions, patients are encouraged to verbally express their feelings—about being in the hospital, the treatment program and the topics under discussion.

The first three sessions are utilized to acquaint the patient with the unit and its few hard and fast rules; to discuss with the patients the reasons why they are in the hospital and what they might hope to accomplish while there; and to explain the rehabilitative treatment program so that the patients will know what to expect from the staff and what the staff will expect from them.

In other sessions topics such as the physical and psychological effects of alcohol, personality development, emotional problems, vocational problems, people and their problems, and sources for continuing therapy in their home communities after they leave the hospital are explored with the patients. In addition to short lectures or talks by the staff followed by discussion, educational films are used as the means of presenting material and stimulating discussion.

Open discussion sessions are interspersed to give the patients the opportunity to ask questions and to bring up any subject they would like to talk about or hear discussed by the staff.

2) Work therapy

All patients who are physically able to do so participate in work therapy, or industrial therapy as it is sometimes called in the hospital setting. Work therapy simply means that the patients are given a useful and responsible job to do in the hospital to which they go daily, as in a regular job.

The patients are most frequently assigned for duty in the various dining rooms of the hospital and Dobbin Infirmary, where the aged and infirmed, completely bedridden female patients are cared for. The performance of tasks such as lifting bedridden patients and feeding patients who can't feed themselves, is a valuable service to the patients and the hospital. Many patients report that "being of service to other patients" gives them a "feeling of satisfaction" which they haven't experienced for years. This feeling of satisfaction which is derived from doing useful work successfully is a therapeutic experience for those who may have had a succession of disastrous job experiences.

Another response from work therapy reported by the patients is the feeling that "I'm not so bad off after all." This comes from the fact that in the dining rooms as well as Dobbin Infirmary they come in contact with other patients who have little or no contact with reality whom they perceive as being "worse off than me." This reaction is but a short thought away form "Maybe there is hope for me" and, with just a little more insight, can lead to "Perhaps there is something I can do about my condition."

3) Patient government

Patient government and work therapy are closely associated therapies. Both create a situation in which the patient can re-experience what it is like to be trusted with responsibility. Most patients say that it makes them "feel better inside." Patient government is charged with the responsibility of running the ward, making work therapy assignments, and enforcing the few rules of the hospital. The latter are: a) no smoking in the rooms; b) no drinking; c) patients are not to make telephone calls for other patients; and d) each patient must keep his own room clean. Running the ward includes making additional rules as needed and handling infractions, and assigning communal work details on the unit and operating the "Coffee Room."

The "Coffee Room" is a patient-institution within the unit. Here coffee flows freely, night and day, from a coffee pot furnished by the hospital along with one pot of coffee a day. Otherwise funds are collected through patient government for its support. Furnished also with a refrigerator, milk and fruit juices are provided by the hospital. The Coffee Room is the scene of many heated patient "bull sessions," and spontaneous patient "group therapy" sessions.

Actually patient government is scheduled as any other group therapy session, but it is different in one major respect—staff members may not attend unless they are invited. The patients elect their own leaders and conduct their own meetings.

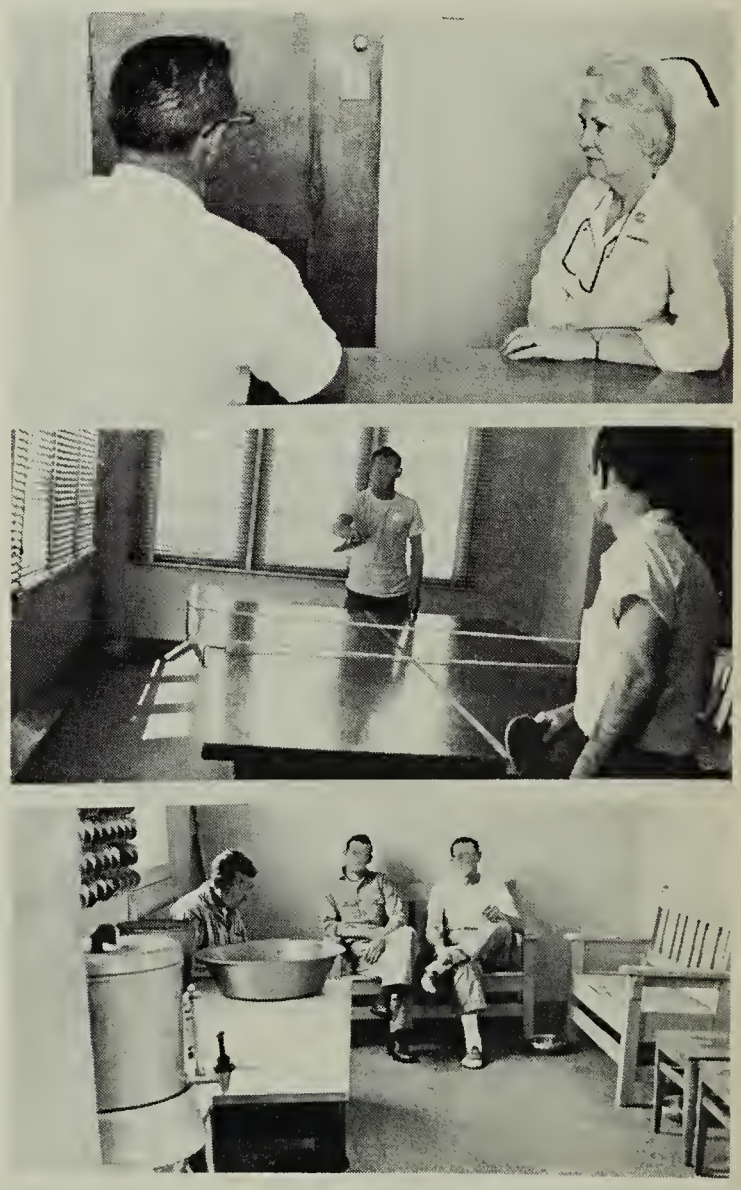
4) Recreation and occupational therapy

What to do with "free time" in the hospital is analgous to what to do with "leisure hours" outside the hospital. If the patient can learn to solve the former, it may carry over into the latter. For this reason, the staff encourages camaraderie, social gatherings, indoor and outdoor recreation, and the development of avocational and hobby interests.

Some recreational activities are provided or planned by the hospital or staff. These include a weekly entertainment movie and occasional parties. The patients plan and carry out others. Activities outside the hospital include attending N. C. State Universitiy ball games, going to wrestling matches, taking walks and going fishing. On the unit the patients watch television and play cards, checkers, aggravation, ping pong and pool or sit in the Reading Room quietly reading or meditating as they wish. On occasions when a number of musically inclined or talented patients are on the unit at the same time, the recreation therapist will bring up a collection of musical instruments to supplement the piano and a musical jam session will ensue.

The patients, at specified times, may make use of the Occupational Therapy Department of the hospital where hobbies or avocational interests can be developed or pursued under the guidance of a professional staff member.

In many cases recreation and occupational therapy prove to be more than



time fillers. Some of the patients happily find out for the first time in years that it is possible to "enjoy oneself" or "have a good time" without drinking.

5) Spiritual therapy

Religion as one important area of a person's life may very well come up for discussion in group therapy sessions. However, the patient's individual religious beliefs or lack of them are respected as a private matter. They become a concern of the staff only when they are presented by the patient as a problem area in his life. Patients who choose to do so may attend services in the Dorothea Dix Hospital Chapel each Sunday. When spiritual counseling is desired by a patient, the staff will arrange an appointment for him with the chaplain.

6) Individual counseling

Individual counseling with the regular unit staff goes on informally all the time. At any time during the course of rehabilitative treatment, patients may request and get formal individual counseling time from the staff also. In addition to the physician, nurse and social worker assigned full-time to the Alcoholism and Drug Addiction Unit, formal counseling time is available, on request, from a psychiatrist, psychologist, industrial therapist, occupational therapist, vocational rehabilitation counselor and chaplain.

7) Nightcare

The hospital and staff has experimented in a limited way with the concept of nightcare, meaning that the patient is allowed to obtain a job locally to which he goes during the day and spend his nights at the hospital as a patient on the unit. The patient on nightcare usually is working in individual therapy with some member of the staff, and his complete release to the community is gradual. For instance, after first being allowed to leave the hospital entirely, the patient is brought back to the hospital for consultation three times a week for two weeks. Then, gradually, on a decreasing basis, he is seen less and less over a period of several months. On each return visit he is seen by a designated staff member for interview and counseling.

8) Alcoholics Anonymous

Alcoholics Anonymous is a fellowship of "men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism." A.A. is the major outside source of continuing help that is readily available to all patients. Members of A.A. are invited to come to the hospital each Sunday evening to explain the fellowship, its purposes and program, and to conduct a meeting. This gives the patients the chance to learn while still in the hospital how to take advantage of A.A. on the outside. Sometimes some of the patients really get enthusiastic and hold their own A.A. meetings at other times. Attendance is voluntary at the insistence of A.A., but is highly encouraged and recommended by the staff.

What can the program accomplish?

The aims of this treatment program are modest. They have to be in view of its limited staff and the fact that so little is **really** known about the treatment of alcoholism or other addictions. This program can dry the patient out or get him sober. If the patient remains for 28 days, it can perhaps give him the first prolonged period of sobriety he has experienced in some time. Hopefully, during this period, the staff can get the patient to thinking about his predicament —just where he is in life. Is he satisfied with the situation? Or would some other life pattern be more desirable? Once the patient gains enough insight to make this choice, the staff can begin helping him construct plans to build a new life. Regardless of whether this takes place, the staff can make every effort to refer him to another source of help in his community—A.A., physicians, social agencies, Flynn Homes and mental health clinics, among others.

CONTINUED FROM PAGE 4

Hermes. Three weeks later, my wife and I sat in the very same courtroom where I had been previously tried. However, this time we sat together and listened overjoyed as the very same judge ordered immediate return to us of our other two children. We were once more a whole family. I could expound with joyous rhetoric for many uninterrupted hours about the happiness I felt; but, I believe one of my actions at the time is indeed worth a thousand words. I would ride the bus to town and immediately board a returning one, just for the wonderful feeling derived from going home to my family.

Elation Tempered

This initial elation, however, was soon tempered by the rigors encountered during the long fight to reach respectability once more and a certain amount of affluence. As they who have traveled it say, "the road is not an easy one." At times we were jarred by certain of the "ruts" and "bumps." Only last year I found myself in the hospital undergoing major surgery. But I have discovered as undoubtedly others have discovered before me that "the harder the fight, the greater the victory." At the end is to be found a foundation as unshakable as a martini.

This is what it was like for me from four years ago until now. I have enjoyed sobriety all of this time and I owe to sobriety the very existence of my family. Even so I am neither reformer nor prohibitionist. Moderation, I believe, in anything is fine. I only wish I could have recognized and heeded the true danger signals in my early years—when the two martinis before dinner became three and the three scotches in the afternoon became five.

Epilogue

If this seems to be the beginning of a different story, in a way it is. I am writng these final words in my room at the Sheraton - Baltimore Hotel across from Johns Hopkins Hospital. My oldest son has fallen asleep following a hectic day of tests and examinations. He is the one who had the heart operation. The doctors have told me today his condition is very good, so good that they do not wish to see him for another two years. It is hoped that he will make it to his early teens before further corrective surgery is necessary.

As I now watch him sleep, I am struck by the preposterousness of attempting to use mere words to describe my feelings. A far easier task would be to give an acceptable definition of "war" or "childbirth," another impossibility. Yet, even though it is a wonderous feeling, this is not the most remarkable aspect of the situation. The most amazing thing is that my son and I came here to Baltimore **alone**, my wife and other children remaining in Charlotte. During my drinking days, I would not have been allowed to take him as far as the corner drugstore.

Yes, life is stranger than fiction. Care for a footnote?

I have at long last entered the field of employment which I had often thought I would enjoy and had the capabilities for, the one I wish to make life-long. The prognosis is great. One of my employers is also great; he is the very same judge who sentenced me, set me free, and returned to me my family.

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

EVER since its genesis as an item of human behavior, numerous values have been assigned to the use of intoxicating beverages. Alcohol, among other things, has been praised as a medicine, as a social lubricant which facilitates communication and strengthens group bonds, and as a behavior modifier that disconcerts the individual from the tensions of daily living. Yet, despite these valuations, drinking has often been regarded as a bane and attempts have been made to control or to abolish it.

The acme of alcohol control in this country was the temperance movement which started about 1830 and lasted approximately one hundred turbulent years. This movement was based on the assumption that all forms of alcohol intake led to personal tragedy and societal ills and, therefore, had numerous and dramatic consequences for the individual and society. The aim in this respect was to develop a system of law and coercive measures which would serve to eliminate the custom of drinking from the national scene. Thus, prohibition became the goal and many groups emerged and worked assiduously for a legal decree against alcohol. This agitation finally culminated in the Eighteenth Amendment to the Constitution which meant in essence the forbidding by law of the manufacture, transportation and sale of all alcoholic beverages.

The failure of prohibition has been well documented and includes such factors as the lack of effective mechanisms to enforce the law, the high costs of enforcement, corruption in public office and, primarily, the absence of popular support. With the failure of this unilateral and authoritarian approach to alcohol, other forms of control emerged to diminish the costs of excessive drinking. One of these forms, which has gained increased momentum in recent years, is the modern alcohol education movement. This approach is based on the scientific gathering of facts about intoxicants and their use and the objective dissemination of these facts to the general public. Unlike previous attempts to regulate alcohol misuse, this approach maintains a neutral stand, neither pleading for nor against the practice of drinking. Rather it endeavors to present dispassionately the growing body of information about alcohol and alcoholism in order to assist all citizens to formulate for themselves acceptable standards of conduct regarding al-

No one program of alcohol education can be applicable to all subgroups within the community.

Attitudes Toward Alcohol Education:

A COMPARATIVE STUDY OF NEGRO AND WHITE COMMUNITY MEMBERS IN MISSISSIPPI

BY GERALD GLOBETTI

This study was conducted by the Department of Sociology and Anthropology, Mississippi State University, with the cooperation of Mrs. Vashti I. Cain, supervisor of alcohol and narcotics education, Mississippi State Department of Education and was supported by a research grant from the National Institute of Mental Health, U. S. Public Health Service. The author is an associate professor of sociology at Mississippi State University.

cohol. In this way, it is hoped that the problems arising out of the misuse and abuse of beverage alcohol will be reduced.

Currently, there is an abundance of scientific information concerning the nature and the use of ethyl alcohol. Many early ideas are either being discarded or revised while new ones are being developed. However, despite the availability of materials essential for good instruction, the problem of proper means of disseminating this information to the layman still remains. That is, the objective gathering of facts about alcohol has come about much easier than has the objective transmission of these facts. There is yet a lack of consensus concerning the goals of alcohol education. This has been further complicated by the numerous controversies that are still being waged about drinking. Emotions regarding alcohol are to such an intensity that the subject of alcohol education is too sensitive for easy discussion in many communities.

Statement of the Problem

However, in spite of these types of barriers, the Sociology Department at Mississippi State University, under the auspices of the National Institute of Mental Health and with the cooperation of the State Department of Education has initiated a demonstration community oriented alcohol education program in two Mississippi communities. The aim of this program is to show that it is possible to satiate a community with information about alcohol and alcoholism, thereby, creating an awareness of local needs in these areas, as well as a means to meet these needs. This program has as its guiding philosophy to objectively teach the scientific facts about alcohol through a comprehensive effort utilizing all existing community structures and resources to their maximum potential. This will involve the development of research, information services and the assistance of alcohol educators in the planning of instructional programs for high school students, church, business, civic, health and public service groups.

As a part of its preliminary planning, one of the questions to which this program required an answer was a delineation of the factors which would tend to contribute to or retard its implementation in different community subgroups. This paper, therefore, is concerned with a comparative analysis of the attitudes of Negro and white community members toward alcohol education. Four major topics are studied; namely, the respondents' (1) current level of participation in formal alcohol education activities; (2) awareness of needs in the areas of alcohol and alcoholism; (3) opinions and conceptualizations of alcohol education programs; and (4) images of the alcoholic and alcoholism.

This report is prompted by the fact that in the communities involved in the alcohol education program, the Negro and the white person represent two distinguishable subgroups or, in other words, that particular patterns of behaving and values can be identified in each. Thus, it is assumed that the variations that exist between the two racial systems in terms of cultural life styles will be reflected in differences in the definition of alcohol and, consequently, attitudes toward alcohol education. Within the cultural system of a group of people, there is an image of beverage alcohol which, in turn, determines the type of response men make toward it. Subsequently, explanations of a person's behavior and attitudes concerning alcohol can be

accounted for in large measure by the cultural prescriptions for intoxicants that are included in the social system of which he is a member.

Furthermore, this study is prompted by the need to eliminate much of the impressionistic speculation regarding the subject of drinking in the Negro subculture of the South. Drinking is often associated by the lay public with increased impulsive activity of an agressively or sexually oriented nature. It is commonly felt, at least in the popular mind, that the Negro subculture displays a greater tolerance for impulsively oriented behavior which leads to the belief that the Negro is not heavily cautioned against drinking and is given more opportunity to obtain and use alcohol. This implies that the members of the Negro subsystem may be less tolerant of an alcohol education program which purports to reduce the effects of abusive drinking. However, reliable information to indicate if alcohol use is less restrictive among Negroes as compared to whites is almost non-existent and needs to be examined.

Research Procedures

This analysis is based upon a universe of the household heads or homemakers of residence units included in the 1965 city directories of the communities involved in the survey. A simple random sample consisting of 452 respondents was taken—146 Negroes and 306 whites. Of this number, 108 of the Negro and 219 of the white household heads or homemakers were contacted by personal visitation and interviewed from a pre-tested schedule consisting of both closed and open-ended questions.

When the data are amenable, the chi-square test of significance is used to determine if there are true differences between the Negro and white respondents on the items examined. However, in some cases, the responses were of such a nature that this statistical model could not be applied. That is, because of the small number of cases in some response categories, collapsing of the data would have been imperative for the test. Yet, in doing this the value of the individual responses would have been lost.

Findings

Level of Participation in Formal Alcohol Education Activities:

The data indicated that, in general, very little time had been devoted by the members of both racial groups to the formal study of alcohol and alcoholism. However, the white respondents were somewhat more likely than their Negro counterparts to have engaged in some type of instructional program. For example, 12 percent of the white residents as compared to 5 percent of the Negro residents had paricipated in discussion groups, study programs or seminars devoted to the subjects of alcohol use and alcohol addiction. When asked if they had ever attended a course of study, workshop, or an institute concerned specifically with these topics, 2 percent of the Negroes and 10 percent of the whites replied in the affirmative. Yet, the difference between the racial systems in terms of current participation in any type of formal alcohol education activity was practically nil. In other words, neither the white nor the Negro residents were engaged in formal instructional programs at the time of the survey.

Source of Information About Alcohol and Alcoholism:

In the absence of formal programs of learning, it was found that the respondents relied on a variety of

(Continued on page 26)

MEDICAL TRE

BY RICHARD C. BATES, M.D., F.A.C.P.

Medical treatment should embrace recruitment into therapy, detoxification (initial therapy), education of the patient (intermediate therapy), and referral for long-term care (definitive treatment).

Dr. Richard C. Bates of Lansing, Michigan, a practitioner of internal medicine, is also medical director of the E. W. Sparrow Hospital's alcoholism program. This article is based on a talk he gave at the annual meeting of the North American Association of Alcoholism Programs last fall.

SINCE alcoholism is a disease, the term "medical" as applied to treatment should be understood to embrace all the aspects of treatment from start to finish. It is a commentary on the medical profession, as well as upon the disease, that the adjective *medical* in this context has come to denote only the treatment of alcohol intoxication and, sometimes, unfortunately, to mean the attempt to treat alcoholism by substituting some more dangerous chemicals for alcohol in the hope that a patient who cannot control one intoxicant will somehow be able to control others. (Since physicians are the only therapists allowed to prescribe alcohol substitutes, this approach is legally only tried by them.)

I should like to use this title of *medical* treatment to embrace all areas of the treatment of alcoholism, including recruitment to treatment, where I think a general practitioner, psychiatrist or internist can produce a useful change in the course of an alcoholic's disease, whether by physical or intellectual intervention, directly or through intermediaries.

Let's first discuss the situation where a wife asks for help with an alcoholic husband who refuses to recognize his disease. If she is typical, she will ask that her request be kept secret and she will want a formula for a quick and easy cure.

In this instance, I work on the wife. She is there for one thing, and at that moment she is the only person in contact with the alcoholic. First, it will be important to evaluate her stage of financial and emotional dependency upon him, as well as the degree to which she is chained to inaction by fear—fear of him, of his relatives, of the community and of a husbandless future.

My experience is that the recalcitrant alcoholic's wife can only help her husband when she can convince him that she could get along without him. This means that she should be able to support herself and her children. Emotionally, she should be able to live away from him with at least as much happiness as she has with him.

If these conditions are not present the physician can explore with her ways of attaining them. If those avenues are not open, it does *not* mean that the situation is hopeless, but only that the wife is powerless to intervene productively.

If she *is* suitably independent, she is advised to open the campaign by telling the husband of our visit and of my advice. If she cannot be that forthright, I give her alcoholism

pamphlets to read and leave in sight about the house. Next, she should begin going regularly to Al-Anon meetings, whether or not he objects, both to learn about herself and about his illness as well as to demonstrate that she is actively engaged in doing something about it. While she is still in my office for the first visit I usually make arrangements by telephone for a member of Al-Anon to pick her up at home and escort her to her first meeting. Then I give her a return visit or have my secretary remind me to call her in one month so that she will be assured of my continued involvement.

At the end of that month if no progress is apparent despite her continued attendance at Al-Anon, she is advised to tell her husband that I have recommended a trial separation. The effect of this is awaited, and if there is none she leaves home for a few days, then for a week, then for a month, testing the results after each period, both upon herself and upon her husband. If she cannot leave the home because of the children, she must take the more troublesome step of putting *him* out, through legal means, either by initiating divorce or separate maintenance. Legal means must be resorted to as well when he threatens violence or refuses to support the family.

If all else fails, she must be prepared to end up as a divorcee or, in some states, there is the alternate solution of initiating his commitment as an alcoholic to an institution. If the wife is prepared to take these measures from the start, they will seldom be necessary. It is usually only the vacillating, dependent wife who unwittingly gives her husband the false feeling he is winning the campaign because she lets him win so many battles.

During this campaign, which may last from a day to years, we have only one objective—that the alcoholic see someone about his disease. Particularly, we do not accept his promise to stop drinking on his own because it does not involve surrender and admission of alcoholism on his part, nor does it lead to treatment. It's true that a few alcoholics *do* stop drinking without surrender and treatment, but usually such promises to stop drinking are kept only until the pressure is relaxed.

If the wife cannot be used to bring the alcoholic to help, it may be possible to get her permission to discuss his drinking with his employer, or to enlist neighbors, co-workers or law-enforcers in applying pressures upon him. One should not overlook the simple and direct devices of calling him on the telephone and asking him to come in for a talk, or writing him a letter, with enclosures, offering treatment in a sympathetic, loving fashion. I feel that I have failed my obligation to the wife unless I exhaust every means of getting her husband involved in treatment.

New let's discuss the situation where the campaign has brought me, at last, face to face with the alcoholic who, at this point, is often resentful of my intrusion, unwilling to make any concessions and yet desperate for succor. The novice might expect sparks, or even bullets, to fly at this point, but they never do. It is very difficult to be angry with a

smiling physician who opens with something like, "Good, Fred, I'm glad you came. I've been worrying about you because, from what your wife says, you've been suffering, and I think I may be able to help."

Once I've charmed and disarmed him, the first goal is to convince him he's alcoholic—even a man with appendicitis won't submit to therapy until he's personally convinced of the diagnosis. To do this it is necessary to uncover his rationalizations so they can be refuted. The direct approach works well and goes something like this: "I gather there's doubt in your mind that you *are* an alcoholic. In what ways do you feel you differ from one?"

Then I listen patiently and sympathetically, giving him the feeling that the two of us are searching together for an appraisal of the truth. But that truth is not whether or not he can stop drinking—if he couldn't there would be no point in trying to help him—rather, it is whether he can always drink in a controlled, reasonable, moderate and predictable fashion. If he insists that he can, as happens rarely, there is nothing left but to challenge him always to stop after the third drink or then to admit that he's an alcoholic.

If he admits his drinking *is* sometimes unpredictably immoderate, I explore with him the unreasonableness of repeatedly starting to drink when one can never be sure of a happy outcome. At this point my goals are to establish myself as a friend, to enlist his help in a productive exploration of his drinking patterns and to convince him that I have help for him, if he should need it. I avoid leaving him with the impression that I am an antagonistic supporter of his wife, a militant anti-alcoholic or that I care so deeply about his surrender that he can negotiate and manipulate me into a form of help tailored to his desires. Like his wife, unless I can abandon him, I cannot help him and he must know it. Unlike his wife, I can usually establish the fact that I care a great deal about him, and for him, on a mature level that does *not* connote my being dependent upon him. This may be almost his first experience in encountering such a relationship with another human being.

So now we come to the second phase in "medical treatment," *initial therapy.*

If the patient is able to stay dry for five days at a time I believe he can be treated as an outpatient, preferably by Alcoholics Anonymous because it's free, available seven days a week, still the most effective agent for those who embrace it, and because it involves the alcoholic in the treatment of others—which I regard as a primary goal in the therapy of any compulsion or addiction. Whenever I get an alcoholic to the point that he has become an enthusiastic participant in A.A., I rest my efforts and only renew them when, and if, he loses that enthusiasm. But, if he is not able to stay dry for five days, he'll have to be removed from alcohol by some outside intervention.

In the old days, that sometimes meant that an A.A. member had to stay with him day and night. In enlightened communities it now means hospitalization on the alcoholism unit of a general hospital. In our city of Lansing, Michigan, it means ten days in Sparrow Hospital.

First, it means detoxification, not that *we* detoxify the patient, his liver does. While this might be treated as the principal topic in a talk on "The Medical Treatment of Alcoholism," it is really one of the simplest and least important aspects of therapy. In most areas of the coun-

try, medical help for detoxification is not obtained and yet most alcoholics pull through. Almost anything one does seems to work. At some centers it is customary to tie patients down; at others they are talked to. Some put them to sleep, others offer strong, black coffee. Great stress is often placed on intravenous feedings and vitamins, but in the usual case we use neither of these.

In the uncomplicated case, the worst is over in 36 to 72 hours and the suffering is not much worse than that of a hard cold, provided double doses of tranquilizers are given.

There are three complications. The most common is a grand mal convulsion or "rum fit" which occurs frequently in certain alcoholics, and never in others. Some people put all patients on Dilantin Sodium or other anticonvulsants, hoping to ward off a convulsion in the one susceptible in 20. Others say that the convulsions are not preventable by any medication. We use Dilantin prophylactically only on those with a history of previous "fits" and manage to have about one convulsion in 50 admissions. So far no patient has had any detectable permanent damage from a convulsion and the effect of witnessing a rum fit may be most salutory on the other patients.

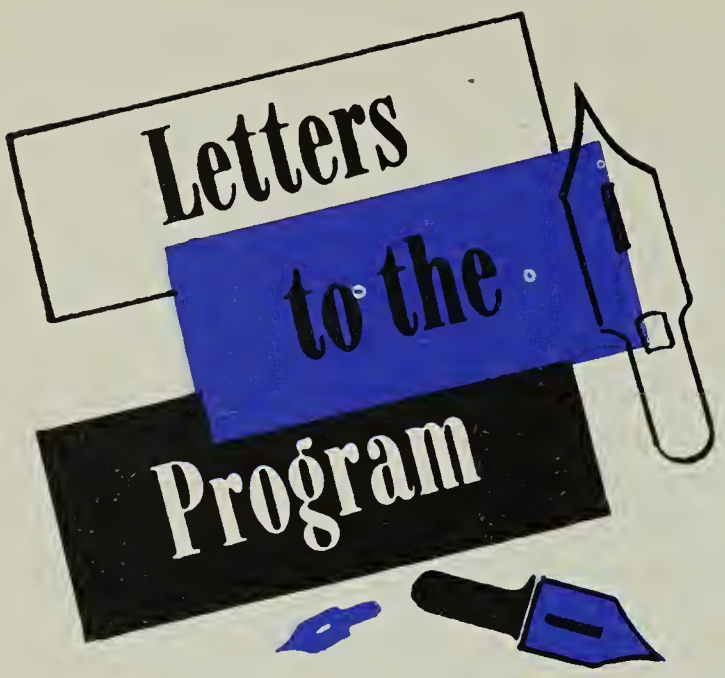
Next in frequency is delirium tremens which is almost certainly a sleep deprivation—more properly a *dream* deprivation—phenomenon. Something about being continuously drunk deprives a man of dreamful sleep. If deprived long enough—only 72 hours in healthy volunteers—certain susceptible people begin to have "waking dreams" or visual hallucinations while awake which they recognize as abnormal at the time and can recall subsequently.

Untreated, delirium tremens were said to carry a ten percent mortality, usually terminating in hyperpyrexia with fever to 110 degrees, broncho-pneumonia and adrenal exhaustion. Properly treated, they need never be fatal. The treatment, and the prevention as well, consists simply of restoring the patient to dreamful sleep. Except on the eastern seaboard, nasty paraldehyde has been replaced with any one of the more elegant tranquilizers. I guess they don't mind a certain amount of air pollution there. Best of all, according both to those who have tried it and those who have experienced it, is a good jolt of barbiturates. Contrary to medical dogma, barbiturates are still the drug of choice in the treatment of any severe withdrawal state. We use them for sleep in every patient. They simply do not cause nor aggravate liver damage nor do they run any more risk of addiction than do any other sedating chemicals. If fact, if given intravenously, since the patient falls to sleep immediately, he has little awareness of any effect at all. Large doses (even 1.0 to 2.0 gms) may be required. To reduce furor, they are usually given intravenously, at a rate of about 0.1 gms every five minutes after the first 0.2 gms until relaxed sleep, deep sleep, is obtained. After 8 hours of this sleep, we awaken the patient, feed him and walk him to the bathroom. If he is still hallucinating (which would be uncommon), a second eight hours of sleep therapy is induced. If adequate levels of relaxation have been achieved, this invariably does the job.

The third complication is acute alcoholic hepatitis progressing to hepatic coma, which I will not discuss because most doctors are well-informed on the topic.

Once detoxified, the alcoholic remains our responsibility in the phase of *intermediate therapy*. Here I try

(Continued on page 25)



Advisory Committee

In the July-September issue of *Inventory* is an article by Alasdair McCrimmon entitled "Point Zero Eight." If possible we would like a dozen copies of this article for use in our committee work.

John W. Morris, M.D., Chairman
Committee Advisory to N. C
Department of Motor Vehicles
Morehead City, N. C.

A.A. Group

Our group recently obtained a copy of *Inventory* through the San Marcos Group. We would appreciate being on your mailing list. We do as much work as we can with the schools, police and other organizations. Your journal would be most helpful.

Secretary
New Braunfels A.A.
New Braunfels, Texas

Mental Health Center

I would like for my name to be included on the mailing list to receive *Inventory*. I think our Cumberland County Mental Health Center may be getting a copy each quarter, however I would like to be assured of seeing it. Thank you.

Ingram C. Parmley, Chairman
Department of Alcoholic Services
Fayetteville, N. C.

Church Library

Would you please enter a subscription to *Inventory* for me? We have a new church library and, as librarian, I would like this book for the vertical file. Thank you.

Mrs. Louise Bass
Chadbourn, N. C.

Registered Nurse

I am a registered nurse working as an alcoholic counselor at the Alcoholic Rehabilitation Unit of Springfield State Hospital. May I please be placed on your mailing list permanently? *Inventory* contains *much* material that is beneficial to me in my work here.

At this time, I am especially interested in the Oct.-Dec., 1967 issue containing material on the subject of "Constructive Coercion."

Helen F. Haley, R.N.
Sykesville, Maryland

IMPORTANT REMINDER

If your mailing address has been, or is being, changed, please send us a notice of your new address promptly. This will enable us to keep our mailing list up-to-date, efficient, and with less expense. Thank you.

CIRCULATION MANAGER

Loners in Vietnam

I have certainly derived so much from your *Inventory,* and since I know the following person from Kona, Hawaii is dedicated in the alcoholic field plus the fact that he works with "loner" servicemen in Vietnam, I would like to make a special plea to you to please place him on your mailing list. I'm sure he will be very grateful, and I am sure that not only he, himself, but also some of our servicemen with whom he corresponds and helps to stay sober will also greatly benefit.

Anonymous
Lincoln, Nebraska

THE SPARROW HOSPITAL PROGRAM

BY RICHARD C. BATES, M.D., F.A.C.P.

Where there is a will, there is almost always a way. Where there is no apparent way, there is almost always a rationalization.

IN 1957 in Lansing, Michigan, then a city of 125,000, we had two general hospitals of 300 beds each and a smaller osteopathic hospital. Psychiatric cases, formerly kept in jail while awaiting transfer to a state hospital, were beginning to be treated in an outlying contagious unit of Sparrow Hospital. Here they vied for attention with infants with dysentery and children with polio. Alcoholics in delirium tremens were locked in barred rooms containing no furniture whatsoever. Alcoholics not in D.T.'s were rejected to be treated at an old house in the country maintained by A.A. members.

Because of financial problems, these people petitioned for community chest aid which was denied when it appeared that their problems were insolvable, but the need for a community-based approach to alcoholism was appreciated so the Greater Lansing Committee on Alcoholism was created. Within eighteen months, thanks to financial help from the Lansing Junior League and the Michigan State Board of Alcoholism, an information center was opened.

When the old house in the country closed its doors, alcoholics not in D.T.'s were taken to the contagious hospital and small classes were held for them once daily. With the development of a new psychiatric unit at the other general hospital and the decline in polio, the con-

Dr. Richard C. Bates, practitioner of internal medicine, is the *voluntary* medical director of the Sparrow Hospital Alcoholism Therapy Unit. He describes this program in greater detail in an article, "Treatment of Alcoholism in a General Hospital," reprinted from *Michigan Medicine* and distributed by the National Council on Alcoholism, 2 East 103rd St., New York, N. Y. 10029. P. S. Bill Keaton is William L. Keaton, M.S.P.H., coordinator for the Flint Committee on Alcoholism, who was instrumental in establishing an alcoholism program at Hurley Hospital, Flint, Michigan.

tagious hospital next closed out.

Fortunately, at that juncture, the administration of Sparrow Hospital agreed to admission of alcoholics to general beds in the main hospital and we startetd our program with one employee as a coordinator on April 1, 1961, five years after the American Medical Association House of Delegates' first action urging general hospitals to treat alcoholics.

Three months later, we were fortunate to be given a separate 13-bed ward solely for the treatment of alcoholism. We have recently been transferred to a newer 19-bed ward, reflecting the fact that alcoholism is tertiary only to delivery and tonsillectomy as a diagnosis in our 400-bed hospital; a diagnosis that has been coded 3,000 times in the last six years and now appears 600 times a year in our records.

From the start we had unlimited access to the knowledge of Bill Keaton and his staff, but lacking a Bill Keaton, we adapted our program in a pragmatic and sometimes startling fashion.

Tried Fresh Approaches

I cannot say we have developed the best program for treatment of alcoholics in general hospitals or that our program could be used in any other hospital. I can only say we have tried as many fresh approaches to the problem as seemed reasonable, and most of them have worked. We have been singularly fortunate in having hospital administrators who have never interfered in our experimentation.

Details of our therapy as presently carried out have been published and are available from the National Council on Alcoholism in a booklet entitled, "The Treatment of Alcoholism in a General Hospital." But let me discuss some of our more unusual features:

First, we have a policy of immediate admission to the ward. This reflects our understanding that alcoholics, especially when intoxicated, should not be subjected to delay and public view nor harassment by possibly unsympathetic clerks and credit managers. Since our unit beds are usable for no other purpose and our nurses treat nothing but alcoholics, it seemed best to let them make decisions about admission on the floor rather than to have them made "out front." I'll confess this was originally done surreptitiously until it became custom, but it has worked well.

In addition to circumventing discussions of the alcoholic's ability to pay, we serendipitously did an end-run around the requirement that patients have to find a physician before they can enter the hospital. In a communty where only a few physicians welcome alcoholic patients, this requirement can be a real barrier to easy admission. The nurses on the floor assign most unattached patients to any of four different doctors at present. Since 40 per cent of our patients come to us from areas outside of our community, our need for local physicians to assign to patients is apparent.

Second, we are never too full to take one more. This policy reflects our belief that an acutely intoxicated person, or one who has just made his first decision to act, should get immediate help.

We always manage to have one more bed by stepping up our discharge rate when the ward is full, assigning priorities on the basis of physical needs, prognosis for recovery, previous admissions and ability to cooperate with a day-care program. At such times we may reduce our usual policy of ten-days' stay on the first admission, while only offering three days' detoxification to those who have been "through the course" on a previous admission.

Third, we try to treat all patients under the same set of orders. This, too, was accidental. Early in our effort I was sometimes awakened as often as three times a night for orders for new admissions. Once or twice a week I had to dress and go to the hospital to examine a new

patient to determine his need for sedatives. As the nurses became more skilled, they taught me how to sedate patients safely and adequately so we mutually agreed on a set of orders that were flexible enough to permit them to treat all but the most unusual cases without awakening me. Other doctors were equally happy to give the nurses such freedom, since they obviously knew their business, so now we use identical printed orders on all patients unless the physician specifies to the contrary. An additional by-product has been a large saving in money and an increase in efficiency.

One of our best resulting economies has been in an avoidance of vitamins either by mouth or by vein. Somewhere, eons ago, it became medical dogma that all alcoholics are deficient and will improve miraculously with massive infusions of vitamins at ten dollars a shot, but we find abstinence from alcohol and food work as swiftly.

Unlimited Food

In the place of pills we have a third innovation, **unlimited food.** A refrigerator on the ward is available twenty-four hours a day and in it are fresh stocks of sandwiches, pop, ice cream, cheese, hard boiled eggs, potato chips, cookies: in short, almost every snack (with the exception of a cold beer) one might hope to find on a midnight ice box raid at home. However, there **is** a liquor store across the street and we have no locked doors. Patients are allowed to go out for walks frequently, and still not more than ten in 3,000 admissions have succumbed to an irrepressible urge.

Fourth, we treat the alcoholic in an open fashion. Visitors are virtually unlimited, hospital volunteers and employees circulate through the ward freely and the diagnosis of alcoholism is used openly on all insurance forms and hospital records. This reflects our conviction that if we mean to sell alcoholism as a disease devoid of shame we must act accordingly and stop acceding to alcoholics' desire for anonymity. To further this cause we press our patients to discuss their disease with their minister, their doctor and their employer at the first opportunity.

Fifth, our teaching program is largely staffed by volunteers. We have one of the most intensive programs from the standpoint of time—three hours a day, seven days a week—in the state and the most haphazard from the standpoint of content. At present about fifty different people, mostly ministers, come from one to four times a month to spend an hour with our patients with no instruction as to how that hour is to be spent. We get feedback from the patients, alcoholics being highly critical people in many instances, and have come to believe that the result of this informality has been a rich and varied melange of lectures, group discussion, heated arguments and interaction that sometimes does as much for the volunteer as for the pupil. In contrast to the usual program, where the same material is presentetd at weekly intervals, our programs will certainly not repeat more than once monthly, if at all. For this reason, no patient can refuse class on the basis that he's been with us previously and heard it all before.

A large dividend of this approach (in addition to the fact that it costs us nothing) has been that it gives us a chance to involve people in the community in the cause of alcoholism almost at will. Our coordinator makes out the teaching schedule a month in advance and has become clever in persuading reluctant, disinterested and, even antagonistic people to come and take a class. Once there, her enthusiasm and the obvious needs of our patients usually turn the trick. We particularly search out people in the community who need to have a better understanding of alcoholism—people who are in positions where they could help alcoholics and people who could use us if

they were aware of our services.

Our objects are to show the alcoholic that many people are interested in him and to show many people that alcoholics are worthwhile. You can imagine that any minister who has taught ten classes of alcoholics converts himself to our cause.

Doesn't our program suffer then? How can we be sure everything is taught that should be? How do we know something will not be taught that is wrong or harmful? These are all valid questions that I cannot answer. I only know we have given opportunity to many people to help us with the alcoholic and the rewards in sparking community interest in our work have been enormous, especially among the clergy.

In the event our speakers do not appear, we resort to one of 15 hour-long tape recordings of lectures given previously on the ward. At other times, these lectures may also be prescribed to individuals with particular problems, on an individual basis. The titles include "Depression," "Sex," "Confidence," "Religion," "Jealousy," and "Love." One of the most popular is entitled "Johnny Crane."

Sixth, we take everybody. Well, **almost,** everybody. After five or six times around or when we feel we are being used as a flop house or a drying-out center, we may exclude an individual, but otherwise everyone gets immediate admission. If he can't pay the hospital picks up the tab for a few days, after which we offer him day care which is free. This gives us quite a different alcoholic population than that of any other center in the state, as portrayed by statistics for the last quarter of last year: 48 per cent of our admissions in that period had not worked steadily in the 30 days preceding admission and 19 per cent did not pay their bill.

Our philosophy here is that a non-profit community hospital must care for **everyone** regardless of means and that the destitute alcoholic is as deserving (if not more so) than the affluent. Those who bring us patients from outside areas have been cooperative in not bringing us their indigent population to bear, but I share with you guilt feelings that in most other areas of the state this population is barred from help largely through the failure of local welfare agencies to recognize alcoholism as a disease.

Seventh, we do our best to involve the spouse in therapy. If she brings the patient to the floor, the admitting nurse takes a history from her and urges her to come back for a visit with the coordinator. If there are problems of jealousy or compulsive marital battles; if we are unable to understand the wife as seen through the husband's eyes; we try to get the two of them together and spend an hour listening to them argue. Sometimes the alcoholic is right: his wife **is** a mean, nagging scold who could drive almost anyone to drink. At other times our presence gives him courage to make admissions and apologies to her he could never have made alone.

The wife who is about to divorce, the wife who refuses to go to Al-Anon, the wife who has detached herself emotionally from her husband; these are called on the telephone if necessary and pressed to come and visit with us.

Eighth, we have a harmonious and intimate relationship with Alcoholics Anonymous. A.A. holds introductory A.A. and Al-Anon meetings on our ward three nights a week and the other four nights in the week A.A. members take our patients down to the Alano Club for meetings. A.A. members are encouraged to come to the ward at any time to visit with anyone they like and to bring any alcoholic they encounter in twelfth step work for counseling or admission.

Ninth, we make an effort to maintain the proper milieu for recovery on the unit by sorting out psychotic, deteriorated or psychopathic patients. While we can usually absorb a few of these sicker

people, several on the ward at one time can be most upsetting. At such times the more normal alcoholics will often withdraw to their rooms, avoid classes or sign out against advice. Appropriate discharge or transfer of selected patients can often put our atmosphere back on its usual intimate track.

Tenth, we involve our patients in the care of each other. This enables one alcoholic to see how repulsive he may appear to his wife when drunk. Involving as many as possible when there are rum fits or delirium tremens on the unit can change a group of resentful or apathetic patients in short order. The start of love is to appreciate another's needs as being equal to one's own and teaching alcoholics to start loving in this fashion is a good goal in rehabilitation.

With the exceptions I've listed, we're pretty conventional. We even go over our budget, but not as far as you might think, considering the figures you have heard. In the first 10 months of 1966 the most careful cost accounting showed a total deficit of $8,000 or about $27.00 a day, less than the daily charge to one patient. With our larger unit and, hopefully, with increased income for indigents as a result of Title 19 "Medicare" legislation, we should be clearly in the black from now on. Credit for this happy state can be shared by the large numbers of our volunteers—ministers, doctors, social workers, priests, A.A. and Al-Anon members, inpatients and ex-patients, to say nothing of our hard-working professional staff.

To those of you who feel these solutions would not work in your program—and especially to those who despair of getting an alcoholism program into your hospital—let me say that where there is a will, there is almost always a way. Where there is no apparent way, there is almost always a rationalization. I am proud that Bill Keaton and I come from communities and hospitals where there is a way.

MEDICAL TREATMENT

CONTINUED FROM PAGE 19

to accomplish the work of educating him to the deepest levels of his understanding of these things, and in this order: *First,* he is a typical alcoholic. *Second,* he can never drink alcohol in any amount, ever again. *Third,* achieving sobriety is possible, but will not be easy. *Fourth,* after starting sobriety he will require an average of two years of some kind of therapy to correct the personality deviations that he previously tried to correct with alcohol.

Finally, I try to guide him to help for what will be the *definitive treatment.* I do not believe that the average general doctor is to be expected to enter into the long-term therapy of alcoholism. Not that it is beyond him, but because he has too many higher priorities for his particular skills and because his time is too expensive for most alcoholics to purchase. Furthermore, one-to-one therapy is less efficient than group therapy.

But physicians *can* help in this phase by supporting and encouraging continued sobriety and participation in therapy by picking him up for acute and intermediate therapy again when the relapses occur (as they do in the majority of cases) and by supplying Antabuse in selected cases which can be supplied only by the medical profession.

In summary, the medical treatment of alcoholism should embrace recruitment into therapy, detoxification, education of the patient and referral to proper agencies for long-term care. It requires no skills unusual in the general medical practitioner. And I can asure you that it provides rewards as great or greater than those received from treatment of any other medical disease.

CONTINUED FROM PAGE 15

informational sources about alcohol and that these varied in some respects between the races. Negroes were much more likely than whites to answer that they had no major sources of information about these subjects, 60 percent as compared to only 1 percent. On the other hand, the communication media (television, radio, newspapers and popular magazines) was the chief source of information for both racial groups although over twice as many white respondents were dependent on this source. The second most mentioned source for each group originated from the interviewees first hand experience with alcohol or from personal contact with friends or neighbors who drank. Here again, however, the whites tended to be more dependent on this source of information than were the Negro residents.

No attempt was made to ascertain the content of the information received. However, the quality of the data imparted from the two most mentioned sources is obviously open to question. For example, the information an individual receives through the communication media during his leisure hours is not systematic or well planned. In most cases, attention is directed toward the extreme manifestations of excessive drinking which, consequently, exclude a great deal about intoxicants and their use. Moreover, much of the information one sees on television or hears from the radio is designed to persuade the individual to purchase alcoholic beverages and is hardly worthy to be labeled as a source of information. Furthermore, direct personal experience with persons who imbibe does not necessarily facilitate an understanding of the problems of alcohol. Unhappy associations with an alcoholic or an excessive drinker, for example, may lead to a narrow bias regarding alcohol use which can vitiate the more objective educational approach.

But regardless of the quality of the material emanating from these sources, this finding is insightful. First, it suggests that either the Negro respondents are less receptive than the white respondents to seek information about alcohol or that such sources as the communication media are not used to a great extent among this population. Second, these data demonstrate some channels for adult education which may be employed by the program to effectively reach the public in each racial system.

Along these same lines, inquiry was made as to where the residents would turn if they wanted to learn more about alcohol or alcoholism. Differences were again noted between the racial systems. Negroes were more likely than whites to reply that they did not know where they would seek information on these topics. Of the sources mentioned, the white sample tended to favor in order of preference: people who had experienced a drinking problem (20 percent); a physician (18 percent); reference material (12 percent); a minister (11 percent); and the alcohol educator (6 percent). The Negro interviewee, on the other hand, mentioned: a physician (19 percent); the alcohol educator (14 percent); and minister (7 percent); and reference material and former problem drinkers (each with 5 percent). These data are also instructive in that they provide some discernment into what channels in the communities residents feel are reliable in offering information about alcohol. As a result, it would be beneficial to attempt to include these pub-

lics in the alcohol education program.

Attitudes Toward Alcohol Education:

Another insight that was considered useful to gain was that concerning the respondents' attitudes relative to the need for and the goals of alcohol education. It was found, in this respect, that both the Negro and the white residents recognized a need for alcohol education in their communities and gave strong endorsement to its implementation. This is evidenced in several ways. For example, 73 percent and 75 percent of the Negro and white respondents, respectively, felt the exigency to inform the public about alcohol and alcoholism. Within each racial system, 9 in 10 of those questioned said that more information was needed in the community regarding each of these subjects. In addition, nearly four-fifths of both Negro and whites replied that the communities should make funds available to start or to activate local instructional programs.

Thus, on the surface it appears that the members of each racial group see the need for systematic and articulate programs of alcohol education. However, a closer inspection of the data revealed some marked differences between the white and the Negro sample regarding the goals of the program and its value. In general, Negroes were much more cautious about giving complete endorsement to the program and tended to view it with suspicion. For example, when asked if they felt that education about alcohol was actually a waste of time and money, over one-fourth of the Negro respondents agreed. This compares to only 4 percent of the whites who answered this way. Negroes, more so than their white counterparts, also agreed that alcohol education was impractical, 35 percent and 4 percent, respectively.

Uncertainty or suspicion concerning the goals or the end results of the program was much more prevalent in the Negro than in the white community. Nearly one-half of the Negroes as compared to only 7 percent of the whites felt that instruction about alcohol would simply add to the confusion concerning this topic which already exists in the public mind. The attitude that instruction about alcohol would lead to more drinking among both adults and young people was also much stronger among the Negro population. Such data as this suggest that although Negroes may favor alcohol education, at least verbally, they are disposed to suspect how the program will influence their community.

Moreover, the conceptualization of the goals of alcohol education and their effectiveness in diminishing alcohol related problems varied between the two racial systems. The Negroes were less likely than the whites to feel that problems associated with the use of alcohol existed in their community. Furthermore, there were some notable differences between the racial groups regarding the nature of the problems perceived. The most often mentioned problem in the white community was that of extensive teen-age drinking, 32 percent. Only 4 percent of the Negroes saw this as a problem. This seems to indicate that white parents would be more favorably disposed toward alcohol education in the school system than would parents of Negro youth. Such was the case. Nearly one-half of the Negro adults questioned, for example, said that the school had no responsibility in this area. This compares to only one-tenth of the white residents who felt this way. When asked to agree or to dis-

(Continued on page 30)

A feature designed to help you keep posted on developments in the field of alcoholism.

WASHINGTON, D. C.—The 28th International Congress on Alcohol and Alcoholism will be held September 15-20, 1968 at Washington, D. C. with headquarters in the Shoreham Hotel. The Congress, a quadrennial meeting, is a function of the International Council on Alcohol and Alcoholism. It last met in Frankfurt/am Main in 1964. Stockholm was the site of the 1960 meeting. The 1968 congress is the first in the United States in half a century.

The most important international event in the field, the Washington congress is expected to be the most extensive and best attended in the history of the International Congress. To this end five sponsoring organizations and eighteen additional organizations are cooperating in planning and implementing the meeting.

The sponsors are: the North American Association of Alcoholism Programs; the National Council on Alcoholism; Center of Alcohol Studies, Rutgers—the State University of New Jersey; Society for the Study of Social Problems; and the Christopher D. Smithers Foundation.

The cooperating agencies are: American Hospital Association; American Medical Association; American Nurses' Association; American Psychiatric Association; Canadian Psychiatric Association; General Service Board of Alcoholics Anonymous; International Association of Chiefs of Police; Institute for the Study of Drug Addiction; National Association of Social Workers; National Association of State Mental Health Program Directors; National Tuberculosis Association; North American Judges Association; Al-Anon Family Group Headquarters; American Public Health Association; Association of State and Territorial Health Officers; National Council on Crime and Delinquency; North Conway Institute and the United States Department of Health, Education and Welfare.

The purposes of the International Conrgess are to present scientific findings in the field of alcohol problems; to foster closer relationships and improve communications between governmental and private groups interested in these health and social problems; to encourage further research and professional activity in the field; and to provide through the published proceedings up-to-date knowledge of the biochemical, pharmacological, sociological, psychological and medical aspects of alcoholism.

Congress plenary sessions will be bi-lingual, with English and French the official languages. Bi-lingual translation equipment and personnel will be utilized. Information on the program of the 28th International Congress on Alcohol and Alcoholism will be presented later.

RALEIGH, N. C.: The fifth annual John W. Umstead Series of Distinguished Lectures, held February 1-2, 1968 at Raleigh Memorial Auditorium, attracted a statewide audience of 748 people. "Alcoholism" was the subject of the lectures. Above and below, the distinguished lecturers and other program participants are shown. The subject of the next series, to be held Feb. 6-7, 1969, will be "Organic Disease Perspectives in Chronic Mental Hospitalization."

Samuel Mallov, Ph.D. | **Harrison M. Trice, Ph.D** | **David J. Pittman, Ph.D.**

Eugene A. Hargrove, M.D. | **William P. Wilson, M.D.** | **R. J. Blackley, M.D.** | **Peter N. Witt, M.D**

Judge John M. Murtagh | **Judge David M. Britt** | **Norbert L. Kelly, Ph.D.** | **Ebbe Curtis Hoff, M.D.** | **Thomas F. A. Plaut, Ph.D.**

GREENSBORO. N. C.: The Alcoholism Programs of North Carolina met March 28, 1968 at the Statler Hilton Inn for a one-day meeting during the annual "Alcoholism Information Week" of the Greensboro Council on Alcoholism, host to the meeting. In addition to a business session, the program consisted of talks by three A.I.W. celebrities. George C. Dimas, president of the North American Association of Alcoholism Programs, spoke at a luncheon meeting. The group joined the Greensboro Academy of Medicine in the afternoon at the Jefferson Standard Country Club to hear Morris E. Chafetz, M.D., director of the Alcohol Clinic, Massachusetts General Hospital. George L. Maddox, Ph.D., professor of medical sociology at Duke University, was guest speaker for the concluding session, a 7:00 p.m., dinner meeting. William Hales, associate director of the Charlotte Council on Alcoholism and president of APNC, presided.

George C. Dimas, 2nd from left, was the luncheon speaker. William Hales, standing, presided.

agree with the statement "the child should be taught about alcohol only in the home," six times more Negroes than whites agreed.

The Negro respondents also were more uncertain about the effectiveness of alcohol education in reducing drinking problems. Finally, the interviewees were read a prepared statement of the program's goals and were asked to react favorably or unfavorably toward it. The Negro residents were less likely than the white residents to feel that the goals of the program were appropriate for their community and envisioned opposition to them.

Attitudes Toward Alcoholics and Alcoholism:

One of the long-range goals of the alcohol education program in the two communities is to assist in removing the stigma associated with alcoholism and to create a therapeutic milieu within each community conducive to the rehabilitation of its victims. Thus, as a preliminary phase in meeting the objective, it became necessary to investigate the imagery of the alcoholic and alcoholism in each racial system.

When asked about the etiology of alcoholism, the most often mentioned single cause among both racial groups was that of a weak nature. Negroes were more apt than whites to specify that the illness was caused either by a sinful nature, alcohol, or heredity. The white respondents, on the other hand, were more likely to select multiple causative factors especially those of a personality malfunction and a weak nature.

Information regarding the feelings toward the alcoholic showed that the Negro was more apt than the white respondent to possess a negative image of the person suffering from this condition. As a result, he was less inclined than his white counterpart to feel that community agencies should be involved in solving the problem. For example, nearly four-fifths of the white residents as compared to two-fifths of the Negro respondents replied that the public had an obligation toward the alcoholic. In addition, Negroes were less favorable than whites in advocating the use of community resources in order to treat the illness. Finally, the Negro community tended to harbor some suspicion about a program designed to teach about alcoholism. Approximately 30 percent of the Negro residents as compared to 3 percent of the white sample said that public instruction about this topic was a waste of time and money. Many also feared that education would serve to increase the illness.

Conclusions

This analysis has provided several important pieces of information which are pertinent to the implementation of an alcohol education program in two Mississippi communities. However, it should be mentioned that this paper was a simple comparative study of the attitudes of Negro and white individuals toward alcohol, alcoholism and alcohol education. No reference was made to any personal, social, or cultural factors which may have influenced these attitudes. Obviously, such correlations would have provided much more understanding than the few statistics presented in this paper. Yet some initial impressions can be recorded.

First, this research demonstrates that attitudes toward alcohol education will vary according to ethnic affiliation and membership. Negroes were much less willing to give complete endorsement to alcohol education as a way to effectively control the problems associated with the

misuse of intoxicants. Moreover, they tended to be quite uncertain about the effects of a program of this type on the community. Conversely, the white adults appeared to be disposed toward acceptance of instruction about alcohol and alcoholism and receptive toward its aims. This suggests that the program must begin with a focus on community subsystems. Not all systems in the locality have the same or equally intense problems related to intoxicant use. Consequently, there can be no one program of alcohol education applicable to all subgroups within the community. Instruction about alcohol and alcoholism must be tailored to meet the needs of its potential users.

Along these same lines, an action worker can expect less resistence to alcohol education in the white than in the Negro community. Some type of motivation is imperative in dealing with Negro residents. The suspicion or uncertainty harbored by this population relative to the program also means that the alcohol educator must spend a great deal of time justifying the aims of the program.

Second, it is apparent that the members of both racial groups have devoted little time and effort to a systematic and organized study of alcohol and alcoholism. This was especially true in the Negro community. In addition, the Negro residents tended to have no source of information about these topics at all. Thus, more channels of communication must be developed in this subsystem. This provides a major task for the program personnel due to the traditional segregation pattern in the South which has resulted in little formal structure in the Negro community to work through.

Third, the Negro respondents tend to possess a negative image of the alcoholic and are somewhat confused in their opinions concerning the causes of the illness. This reflects that Negroes are limited in their exposure to current informational sources about alcoholism and, as a result, are not receiving adequate data about it. The Negro, furthermore, is prone to look with disfavor on community programs aimed to assist the alcoholic. The illness in this subsystem is viewed, in general, as being a self-inflicted disorder. Thus, many Negroes feel that the alcoholic deserves his fate, look upon him with disgust, and feel that the public has no obligation in his rehabilitation.

Finally, these data reaffirm the importance of education and social class in the acceptance of new ideas and practices. Changes in approaches to traditional problems are likely to find their strongest opposition among the less educated and lower class groups. The vast majority of the Negro respondents were characterized by these two factors. As a result, they were inhibited from accepting the program by a lack of knowledge and communication, a lack of confidence in experts and a greater fear of the new and untried. Thus, the findings of this paper can possibly be explained more in terms of a pattern of lower-class conservatism than in terms of ethnic differences and values.

Perhaps the major significance of this research, beyond its immediate implications for alcohol education workers in Mississippi, is its demonstration that community subsystems vary in terms of their readiness for alcohol education. Nonetheless despite its limited use, this study can provide a framework as to how an educator might go about assessing a community before an alcohol education program is implemented.

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—Information
—Referral

†Mental Health Facilities
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(Alcoholics and Their Families)
—Outpatient Treatment Services

‡Aftercare or Outpatient Clinics
for
(Alcoholics who have been patients of the N. C. Mental Hospital System)
—Outpatient Treatment Services

ASHEVILLE—

**Alcohol Information Center;* Mrs. Eleanor H. Kerby, Educational Director; Parkway Offices; Phone 704-252-8748.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BEAUFORT—

Carteret County Mental Health and Alcoholism Information Center, Neuse Mental Health and Alcoholism Center; E. D. Woody, Acting Director; 506 Broad St., P. O. Box 82.

BURLINGTON—

**Almance County Council on Alcoholism;* R. J. Cook, Executive Director; Room 802, N. C. National Bank Building; Phone 919-228-7053.

†*Alamance County Mental Health Clinic,* 221 Graham-Hopedale Rd.; Phone: 227-6271.

BUTNER—

‡*Aftercare Clinic; John Umstead Hospital;* Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Calvin Burch, Box 277, Carrboro; Phone: 919-942-1089 or (if no answer) 919-942-1930.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: 704-375-5521.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 316 E. Morehead St.; Phone: 704-334-2834.

CONCORD—

†*Cabarrus County Mental Health Clinic,* 102 Church St.; Phone: 786-1181.

DURHAM—

†*Department of Psychiatry, Duke University Medical Center;* Phone: 648-8111, Ext. 3416.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; 919-682-5227.

ELIZABETH CITY—

*†*Alcoholism Center* (Camden, Chowan, Dare, Pasquotank and Perquimans Counties); Mrs. Rose Pugh, Director; Medical Bldg., P. O. Box 645; Phone: 919-335-1663.

FAYETTEVILLE—

†*Cumberland County Mental Health Center;* Cape Fear Valley Hospital; Phone: 484-8123.

GASTONIA—

†*Gaston County Mental Health Clinic,* 206 N. Highland St.; Phone: 864-8381.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m.-12.00 noon. Thurs., 2:00-4:00 p.m.

†*Wayne County Mental Health Clinic,* 715 Ash St.; Phone: 735-4331.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 919-275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: 273-8281.

†*Family Service Agency;* 1301 N. Elm St.

GREENVILLE—

†*Coastal Plain Mental Health Center,* 1827 West Sixth St.; Phone: 752-7151.

**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Executive Secretary; P. O. 2371; 915 Dickinson Ave.; Phone: 919-758-4321.

HENDERSON—

†*Vance County Mental Health Clinic,* County Home Rd.; Phone 492-1176 or 438-4813.

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 158 By-pass W; P. O. Box 1174; Phone: 919-438-3274 or 919-483-4702.

HENDERSONVILLE—

Alcohol Information Center; S. Robertson Cathey, Director; 2nd Floor, City Hall; Phone: 919-692-8118.

†*Henderson County Health Department;* Phone: 692-4223.

HIGH POINT—

†*Family Service of High Point,* 113 Gatewood Ave.; Phone: 883-1709 or 833-2119.

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 919-883-2794.

LAURINBURG—

†*Scotland County Mental Health Clinic,* 1304 Biggs St.; Phone: 276-7360.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

**Burke County Council on Alcoholism;* Grady Buff, Educational Director; 211 N. Sterling St.; Phone: 704-433-1221.

NEW BERN—

*†*Alcoholism Division, Neuse Mental Health and Alcoholism Center;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 919-637-5719.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: 704-464-3400.

PINEHURST—

Sandhills Mental Health Center; Box 1098; Phone: 295-6851.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone: 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; 919-633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: 633-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholism Program;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: 919-692-6631.

WADESBORO—

†*Anson County Health Department;* Phone: 694-2516.

**Education Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 704-694-2711.

WILKESBORO—

Alcoholism Program, New River Mental Health Center; Roger J. Westmoreland, Program Coordinator; 101 A West Main St.; Phone: 838-3551.

WILMINGTON—

†*Southeastern Mental Health Center,* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; P. O. Box 1435; Phone: 919-736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

**Wilson County Council on Alcoholism;* W. H. Jennings, Director; Room 208, 116 S. Goldsboro St.; Phone: 919-237-0585.

WINDSOR—

**Bertie County Alcohol Information and Service Center;* Rev. Donald Dawson, Director.

WINSTON-SALEM—

*†*Alcoholism Program of Forsyth County, Department of Mental Health;* Robert Charlton, Educational Director; 802 O'-Hanlon Bldg., 105 W. 4th St.; Phone: 919-725-5359.

†*Department of Psychiatry, Bowman Gray School of Medicine;* Phone: 725-7261.

†*Forsyth County Mental Health Unit,* Seventh and Woodland; Phone: 722-0364.

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